

CSHCS CLIENT SERVICE NEEDS QUESTIONNAIRE

Michigan Department of Community Health

Children's Special Health Care Services

P.O. Box 30734

Lansing, MI 48909-8234

Child/Client Name	Date of Interview	County Health Department
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Please describe the following:

1. Child/Client current medical status, treatment regime, pending surgery, etc.:	
2. Daily pattern of care for Child/Client (equipment, prosthesis, nutrition, activity, sleep, etc.):	
3. Impact of Child/Client special needs on family/siblings:	
4. How does the Child/Client feel about their special needs:	
5. Child/Client relationship with peers and siblings:	
6. Family's support system (friends, church, babysitters, respite):	
7. Recreational activities enjoyed by Child/Client and Family:	
8. Family's satisfaction with educational programs and employment status:	
9. Financial impact of Child/Client diagnosis on family:	
10. Other family concerns:	
LHD SIGNATURE	Date Signed

AUTHORITY: Title V of the Social Security Act
COMPLETION: Is Voluntary

The Department of Community Health is an equal opportunity employer, services and program provider.